Claim Reconsideration/Adjustment Form

# of pages (including CAF cover sheet)____

Name of Provider: _____ Molina Healthcare TIN # _____ Date: _____

Member Name	Member ID #	Date of Service				
		To	From	Service Code	Pending Balance	Claim #
1						
2						
3						
4						
5						
6						
7						
8						

Reasons:

1 Reimbursement Difference
2 Authorized Dates
3 Authorization Service #
4 Resubmission with original attached
5 Pending Payment
6 Other Reasons (Explain)

Comments: _____

_____

_____

_____

_____ _____

Signature of Contractor's Name Date

1. Write only claims that are partially paid or denied and re-submit this form with supporting documents.
   a. Copy of the Molina Remittance Advice
   b. Copy of the Original Invoice
   c. Other requesting documents

2. To mail completed Claims Adjustment Form and Claims, please mail to:
   Attention: Texas Claims
   P.O. Box 165089
   Irving, TX 75016